FRONT

BACK

Child's Emergency Medical Authorization

CHILD'S MEDICALLY DIAGNOSED ALLERGIES OR CHRONIC CONDITIONS ETC

CHILD 'S MEDICAL NUMBER

OTHER INSURANCE

IF YES, COMPANY

☐ YES ☐ NO

INSURANCE NUMBER

The Parent/Guardian authorizes immediate medical care and consents to the hospitalization of and/or the performance of necessary diagnostic tests upon, the use of surgery on, **and/or** the administration of drugs to his/her child or ward if an emergency occurs when he/she cannot be located immediately.

SIGNATURE OF PARENT OR GUARDIAN

DATE

NOTE: THIS FORM IS TO BE KEPT BY THE PROVIDER AND IS TO BE TAKEN TO THE DOCTOR OR TREATMENT FACILITY IN CASE OF EMERGENCY

NAME OF CHILD

BIRTHDATE

NAME OF PARENT(S) OR GUARDIAN

ADDRESS

CITY, STATE, ZXIP

MOTHER'S EMPLOYMENT

ADDRESS

CITY, STATE, ZIP

PHONE

FATHER'S EMPLOYMENT

ADDRESS

CITY, STATE, ZIP

PHONE

GUARDIAN'S EMPLOYMENT

ADDRESS

CITY, STATE, ZIP

PHONE

CHILD'S PHYSICIAN OR CLINIC

ADDRESS

CITY, STATE, ZIP

PHONE

032-02-057/2 (10/02)